

**BOARD OF REGISTERED NURSING**

P O Box 944210, Sacramento, CA 94244-2100  
TDD (916) 322-1700  
Telephone (916) 322-3350  
www.rn.ca.gov



Ruth Ann Terry, MPH, RN  
Executive Officer

## **CALIFORNIA BOARD OF REGISTERED NURSING GENERAL INSTRUCTIONS AND APPLICATION REQUIREMENTS REGARDING NURSE PRACTITIONER (NP) CERTIFICATION**

### **GENERAL INSTRUCTIONS**

#### **I. General Application Requirements**

Nurse Practitioner certification eligibility requires the possession of a current, clear and active California RN license. The following must be submitted to the Board of Registered Nursing for Nurse Practitioner certification purposes:

- 1. A completed Nurse Practitioner Certification Application form (Pages 6 & 7).**
- 2. Nurse Practitioner certification fee of \$75.00.**
- 3. One recent 2" x 2" passport type photograph.**
- 4. Required documentation to determine certification eligibility. Please refer to the application requirements for Nurse Practitioner certification (Pages 4 & 5) and select the appropriate method by which to qualify.**

If you do not possess a current, clear and active California RN license and have never applied for a California RN license, an Application for California RN Licensure by Endorsement must also be submitted. If you have had a permanent California RN license, you must renew/reactivate the California RN license.

Nurse Practitioner application fee is an earned fee; therefore, when an applicant is found ineligible the application fee is not refunded. Processing times for certification may vary, depending on the receipt of documentation from academic programs, associations/national organizations or evaluators. Processing a Nurse Practitioner certification application indicating a conviction(s), disciplinary action(s) and/or voluntary surrender(s) may take longer. A pending application file is not a public record; therefore, an applicant must sign a release of information before the Board of Registered Nursing will release information to the public, including employers, relatives or other third parties. Once you are certified, your address of record must be disclosed to the public upon request. All requests for information are mandatory.

#### **II. Name and/or Address Changes**

California Code of Regulations, Section 1409.1 requires that you notify the Board of Registered Nursing of all name and address changes within thirty (30) days of any change. You may call the Board of Registered Nursing regarding the change of address of record. If you have changed your name, please submit a letter of explanation regarding the requested name change plus applicable documentation such as a copy of a marriage certificate, divorce decree or a driver's license.

## GENERAL INSTRUCTIONS (CONT'D)

### III. Social Security Number

**Disclosure of your social security number is mandatory.** Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure, certification or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal of licensure/certification will not be processed. You will be reported to the Franchise Tax Board, who may assess a \$100 penalty against you.

### IV. Reporting ALL Conviction(s), Discipline(s) and/or Voluntary Surrender(s) Against Licenses/Certificates

Applicants are required under law to report ALL misdemeanor and felony convictions. "Driving under the influence" convictions must be reported. Conviction(s) must be reported even if they have been expunged under Penal Code Section 1203.4 or even if a court ordered diversion program has been completed under the Penal Code or under Article 5 of the Vehicle Code. Also, all disciplinary action(s) and/or voluntary surrender(s) against an applicant's nurse practitioner, registered nurse, practical nurse, vocational nurse or other professional license/certificate must be reported.

**Failure to report prior conviction(s), disciplinary action(s) and/or voluntary surrender(s) is considered falsification of application and is grounds for denial of licensure/certification or revocation of license/certificate.**

When reporting prior conviction(s), disciplinary action(s) and/or voluntary surrender(s), **applicants are required to provide a full written explanation of:** circumstances surrounding the arrest(s), conviction(s), disciplinary action(s) and/or voluntary surrender(s); the date of incident(s), conviction(s), disciplinary action(s) and/or voluntary surrender(s); specific violation(s) (cite section of law, if convicted), court location or jurisdiction, sanctions or penalties imposed and completion dates. Certified copies of court documents or state board determinations/decisions should also be included.

NOTE: A certified copy of the arrest report may also be requested. Applicants must also submit a description of the rehabilitative changes in their lifestyle which would enable them to avoid future occurrences.

To make a determination in these cases, the Board of Registered Nursing considers the nature and severity of the offense, additional subsequent acts, recency of acts or crimes, compliance with court sanctions and evidence of rehabilitation.

The burden of proof lies with the applicant to demonstrate acceptable documented evidence of rehabilitation. Examples of rehabilitation evidence include, but are not limited to:

- Recent dated letter from applicant describing rehabilitative efforts or changes in life to prevent future problems.
- Letters of reference on official letterhead from employers, nursing instructors, health professionals, professional counselors, parole or probation officers, or other individuals in positions of authority who are knowledgeable about your rehabilitation efforts.

## GENERAL INSTRUCTIONS (CONT'D)

- Letters from recognized recovery programs and/or counselors attesting to current sobriety and length of time of sobriety, if there is a history of alcohol or drug abuse.
- Proof of community work, schooling, self-improvement efforts.
- Court-issued certificate of rehabilitation or evidence of expungement, proof of compliance with criminal probation or parole, and orders of the court.

All of the above items should be mailed **directly** to the Board of Registered Nursing by the individual(s) or agency who is providing information about the applicant. Have these items sent to the Board of Registered Nursing, Licensing Unit – Advanced Practice Certification (NP), P.O. Box 944210, Sacramento, CA 94244-2100.

**It is the responsibility of the applicant to provide sufficient rehabilitation evidence on a timely basis so that a certification determination can be made.**

An applicant is also required to immediately report, in writing, to the Board of Registered Nursing any conviction(s), disciplinary action(s) and/or voluntary surrender(s) which occur between the date the application was filed and the date that a California Nurse Practitioner certificate is issued. Failure to report this information is grounds for denial of licensure/certification or revocation of license/certificate.

**NOTE: The application must be completed and signed by the applicant under penalty of perjury.**

### V. Temporary Nurse Practitioner Certificate

The Temporary Nurse Practitioner Certificate (TC/NP) is only applicable for the Nurse Practitioner certification applicant who does not possess a **permanent California RN license at the time of application.**

The Nurse Practitioner certification applicant may apply for the TC/NP (Page 16) to bridge the processing time of two (2) to four (4) months for the fingerprint clearances so that he/she may work in California as soon as eligible.

Eligibility for the TC/NP is based on the possession of a temporary California RN license (TL), a complete California RN Licensure by Endorsement application pending the fingerprint clearances that will be processed by the California Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) and a complete Nurse Practitioner certification application.

### VI. Address Information

The Board of Registered Nursing's mailing address is:

Advanced Practice Unit – NP Certification  
Board of Registered Nursing  
P. O. Box 944210, Sacramento, CA 94244-2100

The Board of Registered Nursing's street address for overnight mail is:

Advanced Practice Unit – NP Certification  
Board of Registered Nursing  
400 R Street, Suite 4030, Sacramento, CA 95814-6239

## GENERAL INSTRUCTIONS (CONT'D)

### VII. California Nursing Practice Act

California statutes and regulations pertaining to Registered Nurses/Nurse Practitioners may be obtained by contacting:

Procurement Publications Section  
California Department of General Services  
P. O. Box 1015, North Highlands, CA 95660

Document Number: 7540-957-1108-5 Fee: \$9.95

Telephone Number: (916) 928-4630 - No Telephone Orders Accepted

(Above Information Subject to Change)

## APPLICATION REQUIREMENTS FOR NURSE PRACTITIONER (NP) CERTIFICATION

### METHOD ONE

Successful completion of a nurse practitioner program of study which conforms with the Board's educational standards set forth in the California Code of Regulations Section 1484.

#### **Documentation submitted directly to the Board of Registered Nursing:**

1. Verification of the Completion of a Nurse Practitioner Academic Program form submitted by the nurse practitioner academic program. (Page 8)
2. Official transcripts for the completed nurse practitioner academic program submitted by the nurse practitioner academic program.

### METHOD TWO

Certification by a national organization/association or state board whose standards are equivalent to those set forth in the California Code of Regulations Section 1484.

#### **Documentation submitted directly to the Board of Registered Nursing:**

1. Verification of Nurse Practitioner Certification by a National Organization/Association or State Board form submitted by the respective organization. (Page 9)
2. Verification of the Completion of a Nurse Practitioner Academic Program form submitted by the nurse practitioner program. (Page 8)
3. Official transcripts for the completed nurse practitioner academic program submitted by the nurse practitioner academic program.

## APPLICATION REQUIREMENTS FOR NURSE PRACTITIONER (NP) CERTIFICATION (CONT'D)

### METHOD TWO (cont'd)

The national organizations/associations and state boards listed below have met the certification requirements that are equivalent to the Board's standards for nurse practitioner certification:

- \* **American Academy of Nurse Practitioners (AANP)**  
P. O. Box 12846, Austin, TX 78711 (512) 442-4262 <http://www.aanp.org/>
- \* **American Nurses Association - American Nurses Credentialing Center (ANCC)**  
600 Maryland Ave., SW, Suite 100 West, Washington, DC 20024-2571 (800) 284-2378  
<http://www.nursingworld.org/ancc/>
- \* **National Certification Board of Pediatric Nurse Practitioners & Nurses (NCBPNP&N) or (NAPNAP)**  
800 S. Frederick Ave., Suite 104, Gaithersburg, MD 20877-4150 (888) 641-2767 <http://www.pnpcert.org/>
- \* **National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC)**  
P. O. Box 11082, Chicago, IL 60611-0082 (312) 951-0207 <http://www.nccnet.org/>
- \* **Arkansas State Board of Nursing**  
University Tower Building, 1123 South University, Suite 800, Little Rock, AR 72204 (501) 686-2700
- \* **Florida State Board of Nursing**  
4080 Woodcock Dr., Suite 202, Jacksonville, FL 32207 (904) 858-6940
- \* **New Mexico Board of Nursing**  
4206 Louisiana Blvd., NE, Suite A, Albuquerque, NM 87109-8340 (505) 841-8340

(Above Information Subject to Change)

### METHOD THREE - EQUIVALENCY

A registered nurse who has completed a nurse practitioner program of study which **does not meet** the Board of Registered Nursing's educational standards as specified in the California Code of Regulations Section 1484.

#### **Documentation submitted directly to the Board of Registered Nursing:**

1. Verification of the Completion of a Nurse Practitioner Academic Program form submitted by the nurse practitioner academic program. (Page 8)
2. Verification of Clinical Competency as a Nurse Practitioner form submitted by a **nurse practitioner**. (Pages 10 or 11)
3. Verification of Clinical Competency as a Nurse Practitioner form submitted by a **physician**. (Pages 10 or 11)
4. Verification of Clinical Experience form submitted by the physician **and/or** nurse practitioner. (Pages 12 & 13)
5. Official transcripts for the completed nurse practitioner academic program and/or academic program submitted by the applicable program.
6. Curriculum and course descriptions for the completed academic program for the period of time attended.
7. Submission of the Verification of Required Course Content form to detail the required seventeen (17) areas of course content. (Pages 14 & 15)

**PLEASE REFER QUESTIONS REGARDING THE NURSE PRACTITIONER APPLICATION PROCESS  
TO THE ADVANCED PRACTICE UNIT IN SACRAMENTO AT (916) 324-4607.**

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**APPLICATION FOR NURSE PRACTITIONER (NP) CERTIFICATION**  
**APPLICATION FEE - \$75.00**

**A. PERSONAL DATA (Please print or type):**

Name: (Last) (First) (Middle)			Previous Names (Including Maiden Name):		
Address of Record: (Number & Street)			Date of Birth: (Month) (Day) (Year)		
(City) (State) (Zip Code)			Social Security Number (Mandatory):		
Telephone Number: Home ( ) Work ( )			Mother's Maiden Name:		

**B. RN LICENSURE/NURSE PRACTITIONER CERTIFICATION:**

California RN License Number:		Date Issued:		Expiration Date:	
List <b>ALL</b> States Where You Hold/Held an RN License and Status:			List <b>ALL</b> States Where You Hold/Held a Nurse Practitioner License/Certificate and Status:		
Original State of RN Licensure:		Date Issued:		Expiration Date:	
RN License Number:		Date Issued:		Expiration Date:	
Original State of Nurse Practitioner Certification:		Date Issued:		Expiration Date:	
Nurse Practitioner Certificate Number:		Date Issued:		Expiration Date:	

**C. RN EDUCATION:**

Name of Professional Registered Nursing Program:		Location: (City) (State or Country)	
Type of RN Program: <input type="checkbox"/> ADN <input type="checkbox"/> DIP <input type="checkbox"/> BSN <input type="checkbox"/> MSN		Entrance Date:      Graduation/Completion Date:	

**D. NURSE PRACTITIONER EDUCATION:**

Name of Nurse Practitioner Academic Program:		Location: (City) (State or Country)	
Area of Specialization:		(City) (State or Country)	
Type of Nurse Practitioner Academic Program:		Entrance Date:      Graduation/Completion Date:	
<input type="checkbox"/> Certificate <input type="checkbox"/> Master's <input type="checkbox"/> Post-Master's			

**E. NURSE PRACTITIONER PROFESSIONAL CERTIFICATION (If Applicable):**

Name of Organization/Association or State Board:	Original Date of Certification:
Area of Specialization:	
Certification Number:	Current Renewal/Recertification Cycle Dates:
Method of Certification: <input type="checkbox"/> Examination <input type="checkbox"/> Other (Please Explain)	

**F. BACKGROUND INFORMATION:**

I. Have you ever <b>applied</b> for a Nurse Practitioner certificate in California? If yes: Name at Time of Application: _____ Date Submitted: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
II. Have you ever been <b>issued</b> a Nurse Practitioner certificate in California? If yes: <b>STOP. DO NOT CONTINUE.</b> Please contact the Board regarding whether you should reapply or file a petition for reinstatement of your California Nurse Practitioner certification.	Yes <input type="checkbox"/> No <input type="checkbox"/>
III. Have you ever been convicted of <b>ANY</b> offense other than minor traffic violations? If yes, please explain fully as described in the General Instructions - Section IV. Convictions must be reported even if they have been expunged under Penal Code Section 1203.4 or if a diversion program has been completed under the Penal Code or Article 5 of the Vehicle Code. Traffic violations involving driving under the influence, injury to persons or providing false information must be reported. The definition of conviction includes convictions following a plea of nolo contendere (no contest), as well as pleas or verdicts of guilty. <b>YOU MUST INCLUDE MISDEMEANORS AS WELL AS FELONY CONVICTIONS.</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
IV. Have you ever had a health-care related license/certificate to practice nursing revoked, suspended, placed on probation or otherwise disciplined or voluntarily surrendered in any way? If yes, please explain fully as described in the General Instructions - Section IV.	Yes <input type="checkbox"/> No <input type="checkbox"/>
V. Have you ever had a professional or vocational license/certificate to practice revoked, suspended, placed on probation or otherwise disciplined or voluntarily surrendered in any way? If yes, please explain fully as described in the General Instructions - Section IV.	Yes <input type="checkbox"/> No <input type="checkbox"/>

I understand that I am required to report immediately to the California Board of Registered Nursing if I am convicted of **ANY** offense that occurs between the date of this application and the date that a California Nurse Practitioner certificate is issued. I am also required to report to the California Board of Registered Nursing **ANY** disciplinary action and/or voluntary surrender against **ANY** health-care related license/certificate that occurs between the date of this application and the date that a California Nurse Practitioner certificate is issued. I understand that failure to do so may result in denial of this application or subsequent disciplinary action against my license/certificate.

I certify, under penalty of perjury under the laws of the State of California, that all information provided in connection with this application for Nurse Practitioner certification is true, correct and complete. Providing false information or omitting required information is grounds for denial of licensure/certification or licensure/certification revocation in California.

SIGNATURE OF APPLICANT: \_\_\_\_\_

DATE: \_\_\_\_\_

**NOTE:**

**PLEASE TAPE A  
RECENT 2" x 2"  
PASSPORT SIZE  
PHOTOGRAPH**

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### VERIFICATION OF THE COMPLETION OF A NURSE PRACTITIONER (NP) ACADEMIC PROGRAM

**A. TO BE COMPLETED BY APPLICANT:** Please complete Section A and forward to the program director/representative for the nurse practitioner academic program for completion. Official transcripts submitted must include all completed course work with the certificate/degree status conferred and must be sent directly to the Board of Registered Nursing by the Registrar's Office/Transcript Office. A processing fee may be required for the submission of the official transcripts. Please print or type.

<b>Name:</b>  <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>( Last )</span> <span>( First )</span> <span>( Middle )</span> </div>	<b>Previous Names</b> (Including Maiden Name):  
<b>Address:</b>  <div style="text-align: center;">( Number &amp; Street )</div>	<b>Date of Birth:</b>  <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>( Month )</span> <span>( Day )</span> <span>( Year )</span> </div>
<div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>( City )</span> <span>( State )</span> <span>( Zip Code )</span> </div>	<b>Social Security Number (Mandatory):</b>  
<b>Telephone Number:</b> Home (    )                      Work (    )	<b>California RN License Number:</b>  <b>Expiration Date:</b>  
<b>Name of Academic Program:</b> _____ <b>Specialty:</b> _____	
<b>Entrance and Completion Dates:</b> _____ <b>Type of Program:</b> _____	
<b>Signature of Applicant:</b> _____ <b>Date:</b> _____	

**B. TO BE COMPLETED BY THE PROGRAM DIRECTOR/REPRESENTATIVE FOR THE NURSE PRACTITIONER ACADEMIC PROGRAM:** Please complete Part B regarding the above named applicant and return to the Board of Registered Nursing.

<b>Name of Nurse Practitioner Academic Program:</b>  	<b>Telephone Number:</b> (    )
<b>Address:</b>  <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>( Number &amp; Street )</span> <span>( City )</span> <span>( State )</span> <span>( Zip Code )</span> </div>	
<b>Specialty:</b> _____	<b>Type of Program:</b> <input type="checkbox"/> Certificate <input type="checkbox"/> Master's <input type="checkbox"/> Post-Master's
<b>Entrance and Completion Dates:</b> <b>From:</b> _____ <b>To:</b> _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>( Month )   ( Day )   ( Year )</span> <span>( Month )   ( Day )   ( Year )</span> </div>	
<b>Date Certificate/Degree Status Conferred:</b> (If conferral date and/or status not posted to transcript, please explain.)	
<b>California NP Academic Program Graduates</b> Current School Site Review Cycle Dates: _____	<b>Out of State NP Academic Program Graduates</b> Recognized by a Professional Certification Corporation:    Yes    No If Yes, Name: _____ Program Approval Cycle Dates: _____

I certify under penalty of perjury that the documentation regarding the completion of the nurse practitioner academic program for the above named applicant is true and correct.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Title:** \_\_\_\_\_ **Telephone Number:** ( \_\_\_\_\_ ) \_\_\_\_\_



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**VERIFICATION OF NURSE PRACTITIONER (NP) CERTIFICATION BY NATIONAL ORGANIZATION/ASSOCIATION OR STATE BOARD  
METHOD 2**

**A. TO BE COMPLETED BY APPLICANT:** Please complete Part A and submit to the applicable national organization/association or state board to verify your nurse practitioner certification status. **A fee is required by the national organization/association or state board for the processing of the verification form.** Please print or type.

Name:  ( Last ) ( First ) ( Middle )		Previous Names (Including Maiden Name):	
Address:  ( Number & Street )		Date of Birth:  ( Month ) ( Day ) ( Year )	
( City ) ( State ) ( Zip Code )		Social Security Number (Mandatory):	
Telephone Number: Home ( ) Work ( )		California RN License Number: Expiration Date:	
Name of Academic Program:			Specialty:
Entrance and Completion Dates:			Type of Program:
Signature of Applicant: _____ Date: _____			

**B. TO BE COMPLETED BY THE CERTIFYING NATIONAL ORGANIZATION/ASSOCIATION OR APPLICABLE STATE BOARD:** Please complete Part B regarding the above named applicant and return to the Board of Registered Nursing.

Name of Certifying National Organization/Association or State Board:		Telephone Number: ( )	
Address:  ( Number & Street ) ( City ) ( State ) ( Zip Code )		Method of Certification:	
Certificate Number:	Original Date of Certification:		
<b>Nurse Practitioner Specialty Area:</b>			
Current Renewal Cycle Dates for Certification/Recertification: From: _____ To: _____ (If not applicable, please explain.) (Month) (Year) (Month) (Year)			

I certify under penalty of perjury that the documentation regarding the nurse practitioner certification status for the above named applicant is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Telephone Number: ( ) \_\_\_\_\_ **(OFFICIAL SEAL)**

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## VERIFICATION OF CLINICAL COMPETENCY AS A NURSE PRACTITIONER METHOD 3 - EQUIVALENCY

Verification by a **nurse practitioner AND a physician** of the applicant's clinical competency in the delivery of primary health care is one of the requirements which must be met in order to qualify to use the title "Nurse Practitioner" in California.

**PRIMARY HEALTH CARE** is defined as that care which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease (California Code of Regulations Section 1480(b)).

**CLINICALLY COMPETENT** means that one possesses and exercises that degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary health care (California Code of Regulations Section 1480(c)).

The verifying nurse practitioner and physician **MUST** meet the following requirements:

1. **Current, clear and active licensure to practice.**
2. **Clinical competency in the provision of primary health care.**
3. **Direct observations of clinical practice.**

**A. TO BE COMPLETED BY APPLICANT:** Please print or type.

Name:  ( Last )                      First                      (Middle)	California RN License Number:
Social Security Number (Mandatory):	Date of Birth:  (Month)                      (Day)                      (Year)
Signature of Applicant: _____ Date: _____	

**B. TO BE COMPLETED BY EVALUATOR (Nurse Practitioner/Physician):** Please complete this form and return to the Board of Registered Nursing.

Name:  (Last)                      (First)                      (Middle)		Social Security Number:
Address:  (Number & Street)                      (City)                      (State)                      (Zip Code)		
<b>Profession:</b> <input type="checkbox"/> <b>Physician</b> <input type="checkbox"/> <b>Nurse Practitioner</b>	License Number: Expiration Date: NP Certificate Number:	Dates Employed in Specialty Area: From: _____ To: _____ Professional Specialty:
Method(s) Utilized to Evaluate Applicant's Clinical Competency:		
Period of Clinical Evaluation: From:                      To:		Telephone Number: Home (     )                      Work (     )
<b>I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary health care.</b>		
Signature of Evaluator: _____ Date: _____		

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## VERIFICATION OF CLINICAL COMPETENCY AS A NURSE PRACTITIONER METHOD 3 - EQUIVALENCY

Verification by a **nurse practitioner AND a physician** of the applicant's clinical competency in the delivery of primary health care is one of the requirements which must be met in order to qualify to use the title "Nurse Practitioner" in California.

**PRIMARY HEALTH CARE** is defined as that care which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease (California Code of Regulations Section 1480(b)).

**CLINICALLY COMPETENT** means that one possesses and exercises that degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary health care (California Code of Regulations Section 1480(c)).

The verifying nurse practitioner and physician **MUST** meet the following requirements:

1. **Current, clear and active licensure to practice.**
2. **Clinical competency in the provision of primary health care.**
3. **Direct observations of clinical practice.**

**A. TO BE COMPLETED BY APPLICANT:** Please print or type.

Name:  ( Last )                      ( First )                      ( Middle )	California RN License Number:
Social Security Number (Mandatory):	Date of Birth:  ( Month )                      ( Day )                      ( Year )
Signature of Applicant: _____ Date: _____	

**B. TO BE COMPLETED BY EVALUATOR (Nurse Practitioner/Physician):** Please complete this form and return to the Board of Registered Nursing.

Name:  ( Last )                      ( First )                      ( Middle )		Social Security Number:
Address:  ( Number & Street )                      ( City )                      ( State )                      ( Zip Code )		
<b>Profession:</b> <input type="checkbox"/> <b>Physician</b> <input type="checkbox"/> <b>Nurse Practitioner</b>	License Number: Expiration Date: NP Certificate Number:	Dates Employed in Specialty Area: From: _____ To: _____ Professional Specialty:
Method(s) Utilized to Evaluate Applicant's Clinical Competency:		
Period of Clinical Evaluation: From: _____ To: _____		Telephone Number: Home (     )                      Work (     )
I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary health care.		
Signature of Evaluator: _____ Date: _____		

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### VERIFICATION OF CLINICAL EXPERIENCE METHOD 3 - EQUIVALENCY

Verification of the nurse's clinical experience in the delivery of primary health care is required in order for him/her to use the title "Nurse Practitioner" in California.

**PRIMARY HEALTH CARE** is defined as that care which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for continuity of health care regardless of the presence or absence of disease (California Code of Regulations Section 1480(b)).

**CLINICALLY COMPETENT** means that one possesses and exercises that degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary health care (California Code of Regulations Section 1480(c)).

The verifying nurse practitioner and physician **MUST** meet the following requirements:

1. **Current, clear and active licensure to practice.**
2. **Clinical competency in the provision of primary health care.**
3. **Direct observations of clinical practice.**

**A. TO BE COMPLETED BY APPLICANT:** Please print or type.

Name: <div style="display: flex; justify-content: space-between; font-size: small;"> <span>(Last)</span> <span>(First)</span> <span>(Middle)</span> </div>	California RN License Number:
Social Security Number (Mandatory):	Date of Birth: <div style="display: flex; justify-content: space-between; font-size: small;"> <span>(Month)</span> <span>(Day)</span> <span>(Year)</span> </div>
Signature of Applicant: _____ Date: _____	

**B. TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER VERIFYING THE APPLICANT'S CLINICAL EXPERIENCE:** Please complete and return to the Board of Registered Nursing.

Name of Agency:		
Address of Agency: <div style="display: flex; justify-content: space-between; font-size: small;"> <span>(Number &amp; Street)</span> <span>(City)</span> <span>(State)</span> <span>(Zip Code)</span> </div>		
Name of Applicant's Supervisor:	Supervisor's Telephone Number: Home (    )                      Work (    )	
Title: License Number: Expiration Date:	Dates of Supervisor's Employment: From: _____ To: _____ Specialty Area: _____	
Dates of Supervised Clinical Experience: From _____ To _____ From _____ To _____ From _____ To _____	Number of Hours: _____ _____ _____	Clinical Specialty: _____ _____ _____
<p>I certify under penalty of perjury that I have verified that the above named applicant received the number of supervised clinical hours in the appropriate discipline in clinical practice in the performance of diagnostic and treatment procedures essential to the provision of primary health care.</p> <p>Signature of Supervisor: _____ Date: _____</p>		

**BOARD OF REGISTERED NURSING**

P O Box 944210, Sacramento, CA 94244-2100

TDD (916) 322-1700

Telephone (916) 322-3350

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### VERIFICATION OF CLINICAL EXPERIENCE METHOD 3 - EQUIVALENCY

Verification of the nurse's clinical experience in the delivery of primary health care is required in order for him/her to use the title "Nurse Practitioner" in California.

**PRIMARY HEALTH CARE** is defined as that care which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for continuity of health care regardless of the presence or absence of disease (California Code of Regulations Section 1480(b)).

**CLINICALLY COMPETENT** means that one possesses and exercises that degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary health care (California Code of Regulations Section 1480(c)).

The verifying nurse practitioner and physician **MUST** meet the following requirements:

1. **Current, clear and active licensure to practice.**
2. **Clinical competency in the provision of primary health care.**
3. **Direct observations of clinical practice.**

**A. TO BE COMPLETED BY APPLICANT:** Please print or type.

Name: _____ (Last) (First) (Middle)	California RN License Number: _____
Social Security Number (Mandatory): _____	Date of Birth: _____ (Month) (Day) (Year)
Signature of Applicant: _____ Date: _____	

**B. TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER VERIFYING THE APPLICANT'S CLINICAL EXPERIENCE:** Please complete and return to the Board of Registered Nursing.

Name of Agency:		
Address of Agency: _____ (Number & Street) (City) (State) (Zip Code)		
Name of Applicant's Supervisor:	Supervisor's Telephone Number: Home ( ) Work ( )	
Title: License Number: Expiration Date:	Dates of Supervisor's Employment: From: _____ To: _____ Specialty Area: _____	
Dates of Supervised Clinical Experience: From _____ To _____ From _____ To _____ From _____ To _____	Number of Hours: _____ _____ _____	Clinical Specialty: _____ _____ _____
I certify under penalty of perjury that I have verified that the above named applicant received the number of supervised clinical hours in the appropriate discipline in clinical practice in the performance of diagnostic and treatment procedures essential to the provision of primary health care.		
Signature of Supervisor: _____ Date: _____		

## **NURSE PRACTITIONER REQUIRED COURSE CONTENT METHOD 3 – EQUIVALENCY**

On the form provided, please list the courses which you have successfully completed which meet the same educational standards as a graduate of a Board of Registered Nursing approved nurse practitioner program of study preparing a nurse practitioner. Please contact the Board of Registered Nursing regarding the submission of the required documentation.

Please refer to the following list of the seventeen (17) required course content areas within a nurse practitioner curriculum. It is essential that you record the completion of the course content areas in such a manner that the Board of Registered Nursing will have sufficient information/documentation to evaluate your eligibility for nurse practitioner certification in California. The format on the reverse side may be used and you may duplicate the form as necessary. For specific clarification regarding the standards of education for nurse practitioners, please refer to the California Code of Regulations Section 1484.

1. Normal Growth and Development
2. Pathophysiology
3. Interviewing and Communication
4. Eliciting, Recording and Maintaining a Developmental History
5. Comprehensive Physical Examination
6. Psychosocial Assessment
7. Interpretation of Laboratory Findings
8. Evaluation of Assessment Data to Define Health and Developmental Problems
9. Advanced Pharmacology
10. Nutrition
11. Disease Management
12. Principles of Health Maintenance
13. Assessment of Community Resources
14. Initiating and Providing Emergency Treatment
15. Nurse Practitioner Role Development
16. Legal Implications of Advanced Practice
17. Health Care Delivery Systems

# VERIFICATION OF REQUIRED COURSE CONTENT TO MEET THE EDUCATIONAL REQUIREMENTS FOR NURSE PRACTITIONER CERTIFICATION\*\*

(PLEASE REFER TO THE REVERSE SIDE OF THIS FORM FOR INSTRUCTIONS AND THE LIST OF REQUIRED COURSE CONTENT AREAS)

Required Course Content Area	Course Content Completed in Course (Course Name, Course Number, Dates of Entrance and Completion)	Name of Content Provider/Academic Program	Credit

**\*\* Documentation (transcripts, copy of certificates, course descriptions, curriculum information, etc.) must be submitted to verify successful completion and content of each documented course.**

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**APPLICATION FOR TEMPORARY NURSE PRACTITIONER (NP) CERTIFICATE****INSTRUCTIONS:**

1. The application fee for the Temporary Nurse Practitioner Certificate (TC/NP) is **\$30.00**.
2. The TC/NP will not be issued until the **California RN Endorsement Application** and the **Application for Nurse Practitioner Certification** are complete. Only the fingerprint cards submitted to the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) for processing are still pending.
3. The TC/NP will not be mailed to an in-care-of address or a third party address.
4. Possession of a current and active **California Temporary RN License (TL)** is required.

**PLEASE NOTE: IF YOU ALREADY POSSESS A PERMANENT CALIFORNIA RN LICENSE, YOU ARE NOT ELIGIBLE FOR THE TEMPORARY NURSE PRACTITIONER CERTIFICATE (TC/NP) AND YOUR APPLICATION FEE FOR THE TC/NP WILL NOT BE REFUNDED.**

**TO BE COMPLETED BY THE APPLICANT:** Please print or type.

Name:  ( Last ) ( First ) ( Middle )		Previous Names (Including Maiden Name):	
Address:  ( Number & Street )		Date of Birth:  ( Month ) ( Day ) ( Year )	
( City ) ( State ) ( Zip Code )		Social Security Number (Mandatory):	
Telephone Number: Home ( ) Work ( )		Temporary RN License Number: Expiration Date:	
Name of Nurse Practitioner Academic Program:			
Address:			
Type of Program: <input type="checkbox"/> Certificate <input type="checkbox"/> Master's <input type="checkbox"/> Post-Master's Specialty:		Entrance Date: Completion Date:	
I certify under penalty of perjury that the above information regarding the Application for the Temporary Nurse Practitioner Certificate is true and correct.			
Signature of Applicant: _____		Date: _____	